# STATE OF MARYLAND INSURANCE ADMINISTRATION

## INSTRUCTIONS FOR ELECTRONIC FILING OF SEMI-ANNUAL CLAIMS DATA

## Introduction to Electronic Filing

Electronic filing of Semi-Annual Claims Data is a simple process. The electronic form is user friendly and presented in a simple *survey question and answer* format. Each question's design elicits the appropriate response and information. Some questions offer help to ensure information provided correlates to answers of other questions.

Filers may access the electronic form from any computer that connects to the Internet after entering their assigned FEIN number and entity application type combination. Once a filer completes and submits a form, it is secure and available only to the Maryland Insurance Administration ("MIA"). Once the filers submit the form, they will have the opportunity to print a copy for their records at that time. Filers will not be allowed to view past submissions.

If, after submitting a form, a filer realizes that information provided was incomplete or erroneous, they must contact MIA via email to mc_filings.mia@maryland.gov (note: underscore between "mc" and "filings.mia") with the requested changes. If needed, a blank PDF form is available on the website.

Completion of the form requires the name and contact information of the individual filing the report. Electronic submission of the form to the MIA represents the contact's understanding and agreement that he/she has the authority to complete and file the report and that the information filed is complete and accurate to the best of his/her knowledge in accordance with Maryland laws and regulations.

## Claims Data Filing

**Who must file** – each organization that administers or provides reimbursement for health care benefits on an expense-incurred basis in Maryland must review Code of Maryland Regulations ("COMAR") 31.10.11 to determine its filing responsibilities. In general, third-party payors of health care claims in Maryland must file claims data with the MIA semi-annually. For the purpose of this Regulation, third-party payors ("Payors") are insurers, nonprofit health service

plans, health maintenance organizations ("HMOs"), managed care organizations ("MCOs") and other entities to which another Payor has delegated any or all of its claims processing ("Delegated Agents").

**When to file** – claims data filings are due to the MIA semi-annually. Payors must complete and submit the required information by September 1 for the claims reporting period of January 1 through June 30 of the same calendar year and by March 1 for the claims reporting period of July 1 through December 31 of the preceding calendar year.

- When submitting the required report, the Payor must designate the reporting period by checking the box for the appropriate claims filing report description.

- The electronic form is available for a specified period of time, which is posted on the MIA website. The posting will announce when new filings, as well as corrected reports, may be submitted. Once the filing period is closed, reports will not be accepted until the next period.

**What to report** – filers must report data on all claims for health care benefits provided under an insurance policy, contract, plan or certificate issued or delivered in the State. Health care benefits claims include claims incurred under medical benefit plans, dental benefit plans, prescription drug plans, vision care plans, mental and behavioral health benefit plans, home health care plans, and Medicare Supplement plans.

**What are *Clean Claims*** – defined by COMAR 31.10.11, a Clean Claim is a health care claim submitted by a health care provider and received by a Payor that contains all of the *essential data elements* of the *Uniform Claims Form* and meets the uniform standards of required attachments to the Uniform Claims Form. If a received claim does not meet this definition, it is not a Clean Claim.

A Uniform Claim Form is considered to be the CMS Form 1500 for provider services and the CMS Form UB-92 for hospital services, or their electronic equivalents. ("CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.) The essential data elements of a Clean Claim are identified by:

- COMAR 31.10.11.08 for CMS Form 1500, and
- COMAR 31.10.11.09 for CMS Form UB-92

Payors may report data based on their own less stringent definitions of Clean Claims. Filers must indicate whether they define Clean Claims according to the essential data elements of COMAR 31.10.11, or whether they determine Clean Claims based on fewer than the essential data elements of COMAR 31.10.11.

## Payor Identification Information

Filers access the Semi-Annual Claims Data Filing form via the MIA's designated Internet address using their FEIN number and their entity application type. The Internet address will be on MIA web site: www.mdinsurance.state.md.us.

Unless instructed otherwise, Payors access the electronic form, as follows:

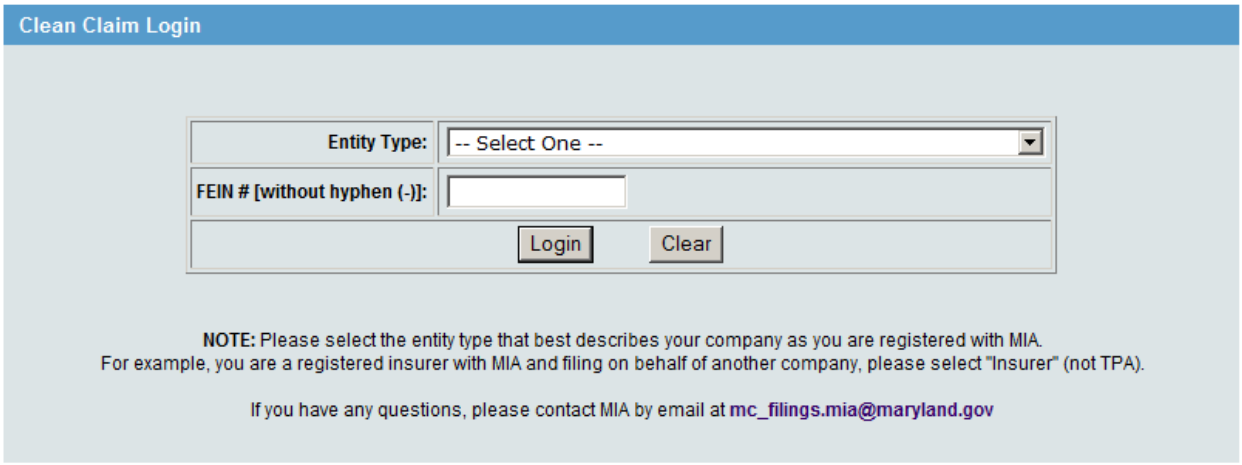
- Insurer (includes all payors except those listed), Health Maintenance Organization (HMO), Managed Care Organization (MCO), Delegated Agent (submitting data for another entity) / TPA, Vision Service Plans (VSP), Dental Benefit Plan (DPO), and Pharmacy Benefit Management (PBM) will use their FEIN number as their user identification number. These Payors must use their FEIN number whether they are filing data of their own, or whether they are filing as a Delegated Agent on another Payor's behalf.

- Payors that are unable to access the Semi-Annual Claims Data form using their FEIN number and entity type should contact the MIA for assistance by sending an e-mail to: mc_filings.mia@maryland.gov (note: underscore between "mc" and "filings.mia"). These entities may have to file paper copies for all reports they file with the MIA whether they are filing data of their own, or whether they are filing as a Delegated Agent on another Payor's behalf.

- Payors should identify one contact for all data filings applicable to a single FEIN number. A single contact may file data for more than one FEIN number.

## Login Information

The login page requires that you enter your entity (application) type of your company as registered with MIA and your FEIN number in order to gain access to the Clean Claim form.



## Completing the Form

There is a sample of the electronic form at the end of these instructions. In general, the form is self-explanatory. Filers respond to a series of specific sequentially numbered questions and instructions by:

- Entering numeric and/or alphanumeric information in the response boxes;
- Selecting items from drop down boxes; and
- Selecting items from a list by clicking the appropriate (radio) button.

Every question requires an answer unless otherwise noted. If the appropriate response is unknown, unavailable or not applicable to the question, the filer should enter "0" for numeric fields, or "NOT APPLICABLE" for text fields, as instructed by the question. A FORM CANNOT BE SUBMITTED IF ANSWERS ARE NOT PROVIDED FOR ONE (1) OR MORE QUESTIONS. In the event the filer attempts to submit an incomplete form, an error message will appear to list the questions needing a response. A form cannot be submitted until all errors are corrected.

Certain answers are formatted. While some questions are answered by selecting items from drop down boxes or by clicking a radio button, others require entry of numeric or text information. Numeric responses should be in integer format (e.g., 185, -220, 91250). Do not use commas or decimals (round to the appropriate whole number). Use upper case or mixed upper/lower case characters for text. Dates should be in mm/dd/yyyy format, phone numbers in xxx-xxx-xxxx format, and e-mail addresses in john.doe@email.com format.

Some responses correspond to other information provided. Survey questions are consecutively numbered (1, 2, 3, 4, 5 etc.). A second level of sequential numbering (1A, 1B, 1C, etc.) groups questions conceptually to help filers relate the information filed electronically to the information previously filed by paper form. Grouping also serves to relate questions for data verification. For example, Question 8, 9, 10 and 11 of the form concern Clean Claims data. Question 8 includes a note stating: 1A= 1B+1C+1D meaning the sum of the answers provided for questions 9.1B, 10.1C and 11.1D must equal the number entered in response to question 8.1A.

Some responses are subject to electronic verification. If an inappropriate response is given, the filer will receive an error message to prompt the correct answer. Error messages are displayed at the time the report is submitted. The filer must return to the corresponding question(s) and correct the error(s). (Note: in an effort to improve the filing process, the number and type of filing responses subject to electronic verification may vary and/or increase from one reporting period to another.)

An amended form may not be submitted electronically to correct data or provide additional information during a filing period. You must use the paper form to amend a report. It may be sent by email to mc_filings.mia@maryland.gov (note: underscore between "mc" and "filings.mia") or fax to 410-468-2245. Please enter a statement in Section VI, question 49 stating the report is an amended return.
Once the electronic form is submitted, it cannot be edited by the filer. Once a filing period is closed, reports may not be submitted until another filing period is established.

Inconsistent, incomplete or otherwise questionable filings are subject to investigation by the MIA. The MIA may contact a filer to explain certain information submitted and may require that an amended report be filed. Claims data filings also may be used by the Insurance Commissioner to determine general business practices and compliance with Insurance Article §15-1003, 15-1004 or 15-1005, Annotated Code of Maryland.

Payors may use the optional comment field at the end of the form to explain certain responses or problems encountered in completing the electronic form. For example, if the current inventory (work-in-process) reported is unusually high, the Payor may wish to explain the reasons the number appears to be inflated or inconsistent with previously reported information. Problems with form completion should also be brought to the attention of the MIA at mc_filings.mia@maryland.gov (note: underscore between "mc" and "filings.mia").

Use a "mouse" or the keyboard "enter" and "up – down" keys to navigate the form. The "*page back arrow*" on the tool bar may only be used to return to input form after you have pressed the "Submit" button and there is an error which requires a correction. You will be able to print a copy of your submission on the processed page.

The form's design features work best when the form is accessed by using the current version of the MSN Internet Explorer or Mozilla Firefox browser. Other Internet browsers may be used. Problems experienced when accessing the form should be referred to the MIA administrator at mc_filings.mia@maryland.gov (note: underscore between "mc" and "filings.mia").

## Form Completion Terms and Tips

The following information is provided to help filers understand certain questions so that they may compile and submit accurate, meaningful data to the MIA.

**Who is filing** – Questions 2, 3, 4 and 6 identify the form filer. Question 3 is already filled in and cannot be modified. Question 6 should be filled in with the Payor's NAIC Group # if exists. Questions 39 and 40 are who the report is about. These two questions must be filled in even if they are the same as Questions 2 and 3. If a Delegated Agent is filing the report, it must properly respond to 41 to identify the Payor for which it is reporting. Questions 42 – 48 pertain to the entity filing the report.

**All Claims** – means all Clean Claims plus all other health care claims submitted by a health care provider or covered person and received by a Payor for processing.

**Claims Inventory** – is the total number of claims awaiting processing comprised of pended claims and claims received but not yet paid, pended or denied. The beginning inventory of one period should equal the ending inventory of the previous report period.

**Adjudicated Claims** – are claims that were paid, partially paid or denied payment during the report period. The adjudication date is the date a payment or denial notice is *issued* (e.g., mailed) by the Payor. **Questions 12, Note: 2A must = 2B+2C (e.g. 2A=20, 2B=10, 2C=10)**

**Interest Paid** – is the amount of interest paid on claims not processed within 30 calendar days pursuant to Insurance Article §15-1005.

**Most Prevalent Reason for the Denial of Claims** – means the most frequent reason(s) a majority of claims received by a Payor are denied for payment. Payors can identify up to 5 (five) reasons for claim denials based on the frequency of their occurrence (e.g., reason #1 – BILL; reason #2 – NONCOVERED; reason #3 – COB, reason #4 – UCR, reason #5 - NOT APPLICABLE). For claims with multiple denial reason codes, indicate the primary or first denial code. To simplify data collection and promote meaningful analysis, Payors must categorize their responses to conform as best as possible to the following denial reason code list:

1. ACCIDENT details needed from insured or provider; includes Workers Comp investigation details
2. ADDITIONAL miscellaneous information not described by other denial reasons but is needed from patient or provider to process claim
3. AUTHORIZATION (pre-treatment authorization) not obtained; provider referral not obtained; unauthorized services received are not covered
4. BILL error or discrepancy; required billing information incomplete or missing
5. COB (excepting Medicare) other coverage information needed; primary payor EOB needed
6. DUPLICATE expense or claim received was previously considered or paid
7. EOB (Explanation of Benefits)
8. INELIGIBLE claimant not covered or coverage not effective at time of service
9. MAXIMUM plan reimbursement exceeded; plan service frequency limit reached
10. MEDICARE all Medicare issues including coordination of benefits (EOMB needed), deductible not covered or service or expense not approved by Medicare
11. MISCELLANEOUS other reasons for denial not listed or explained by other codes
12. NOT APPLICABLE; zero or no other denials reportable
13. NONCOVERED expense or service; service not reimbursable due to deductible or copay/coinsurance
14. PREEXISTING condition not covered; waiting period exclusion or limitation applies
15. PROVIDER out-of-network, not contracted or covered; service covered by global or capitated fee or other network coverage issue
16. TERMINATED coverage; coverage lapsed, or cancelled; dependent no longer covered; premium payments not current
17. UCR allowable fee amount exceeded; coding problem including bundling or incidental procedure
18. UNTIMELY filing of claim by patient or provider; exceeds plan claim filing limitation

# SEMI-ANNUAL CLEAN CLAIM DATA FILING FORM

***(Following is a sample of the electronic semi-annual claims data filing form.)***

SEMI-ANNUAL REPORT OF CLEAN CLAIM DATA — Due twice each year (COMAR 31.10.11.00)

Hello, Insurance Company Name (xxxxxxxxx)
-- Logout --

**Clean Claim Data Filing Report for 01/01/2013 - 06/30/2013**

Note: *For those fields that are not applicable, enter zero (0). Please do not use commas.*

| | | | |
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| 1. | AA. | Today's date (mm/dd/yyyy) as the claims data filing date. | 08/14/2013 |
| 2. | AB. | Full company name of the Payor submitting this report. | Insurance Company Name |
| 3. | AC. | FEIN # [without hyphen (-)] (and NAIC # if applicable) of the Payor submitting this report. | xxxxxxxxx / NAIC # xxxx |
| 4. | AD. | Select the best description of the Payor submitting this report. | Insurer (includes all payors except those listed below) |
| 5. | AE. | What is the report period for this semi-annual claims filing? | 01/01/2013 - 06/30/2013 |
| 6. | AF. | Enter the Payor's Company Group # if applicable. | xxxx |
| 7. | AG. | What data elements are required on the CMS Form 1500 and/or Form UB 92 uniform claim forms for the Payor to determine Clean Claims? | ○ All of the essential data elements specified by COMAR 31.10.11<br>○ Fewer than all of the essential elements specified by COMAR 31.10.11<br>○ Not Applicable |
| | | **Section I** | |
| 8. | 1A. | Enter the number of Clean Claims received (on CMS Form 1500/UB 92 claim forms only and having the required data elements). | |
| 9. | 1B. | Enter the number of Clean Claims paid (include paid and partially paid claims). Enter "0" if no paid claims reportable. | |
| 10. | 1C. | Enter the number of the received claims that were denied because CMS Form 1500 UB 92 data were incomplete or missing. Enter "0" if no denied claims reportable. | |
| 11. | 1D. | Enter the number of received claims that were denied because an attachment to the corresponding CMS Form 1500 or UB 92 was incomplete or missing. Enter "0" if no denied claims reportable. | |

| Section II | | | |
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| 12. | 2A. | Enter the total number of adjudicated claims received for this period. | |
| 13. | 2B. | Enter the number of adjudicated claims paid (includes paid and partially paid claims). | |
| 14. | 2C. | Enter the number of adjudicated claims denied payment for the report period. | |
| 15. | 2D.1. | From the following list, identify the best description of the most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for report period. | -- Select One --<br>**NOTE:** For further clarification, please see manual. |
| 16. | 2D.1.1 | Enter the number of claims denied for the most prevalent reason for denial. Enter "0" if no denied claims reportable. | |
| 17. | 2D.2. | From the following list, identify the best description of the second most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period. | -- Select One --<br>**NOTE:** For further clarification, please see manual. |
| 18. | 2D.2.1 | Enter the number of claims denied for the second most prevalent reason for denial. Enter "0" if no denied claims reportable. | |
| 19. | 2D.3. | From the following list, identify the best description of the third most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period. | -- Select One --<br>**NOTE:** For further clarification, please see manual. |
| 20. | 2D.3.1 | Enter the number of claims denied for the third most prevalent reason for denial. Enter "0" if no denied clams reportable. | |
| 21. | 2D.4. | From the following list, identify the best description of the fourth most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period. | -- Select One --<br>**NOTE:** For further clarification, please see manual. |
| 22. | 2D.4.1 | Enter the number of claims denied for the fourth most prevalent reason for denial. Enter "0" if no denied clams reportable. | |
| 23. | 2D.5. | From the following list, identify the best description of the fifth most prevalent reason (explanation) for the denial of claim payment. Enter "NOT APPLICABLE" if no denied claims for the report period. | -- Select One --<br>**NOTE:** For further clarification, please see manual. |
| 24. | 2D.5.1 | Enter the number of claims denied for the fifth most prevalent reason for denial. Enter "0" if no denied clams reportable. | |

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| | | **Section III** | |
| 25. | 3A. | Enter the beginning claim processing inventory (i.e., the number of unprocessed plus pending claims at the start of the report period). This number should correspond to the ending inventory of the previous report period. | |
| 26. | 3B. | Enter the number of claims pending for legitimate dispute or for additional information at the end of this report period. Enter "0" if there are no pending claims. | |
| 27. | 3C. | Enter the number of claims received for adjudication during the report period, but are as yet unprocessed. Unprocessed claims have not yet been paid, denied or pended. Enter "0" if there are no unprocessed claims. | |
| 28. | 3D. | Enter the ending claim processing inventory (i.e., unprocessed plus pended claims) at the end of the report period. (Note: 3D = 3B + 3C) | |
| | | **Section IV** | |
| 29. | 4A. | Enter the total number of all claims paid, partially paid and denied for the report period. All claims processed includes claims received during the report period and previously unprocessed claims. | |
| 30. | 4B.1. | Enter the number of all claims processed in thirty (30) calendar days or less for this report period. | |
| 31. | 4B.2. | Enter the dollar amount of benefits paid or partially paid for claims processed in thirty (30) calendar days or less for this report period. | $ |
| 32. | 4B.3. | Enter the dollar amount of interest paid on any claims processed in thirty (30) calendar days or less for this report period. | $ |
| 33. | 4C.1. | Enter the number of all claims processed in 31 to 60 calendar days for this report period. Enter "0" if no paid claims reportable. | |
| 34. | 4C.2. | Enter the dollar amount of benefits paid or partially paid for claims processed in 31 to 60 calendar days for this report period. Enter "0" if no paid claims reportable. | $ |
| 35. | 4C.3. | Enter the dollar amount of interest paid on any claims processed in 31 to 60 calendar days for this report period. Enter "0" if no paid interest reportable. | $ |
| 36. | 4D.1. | Enter the number of all claims processed in 61 or more calendar days for this report period. Enter "0" if no paid claims reportable. | |
| 37. | 4D.2. | Enter the dollar amount of benefits paid or partially paid for claims processed in 61 or more calendar days for this report period. Enter "0" if no paid claims reportable. | $ |
| 38. | 4D.3. | Enter the dollar amount of interest paid on any claims processed in 61 or more calendar days for this report period. Enter "0" if no paid interest reportable. | $ |

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| | | **Section V** | |
| 39. | 5A. | Enter the name of the company that this report is about. If you are a delegated agent processing claims on behalf of another entity, enter the full name of the delegating entity. Otherwise, enter your company name. | |
| 40. | 5B. | Enter the NAIC number (FEIN number if NAIC does not exist) for the company that this report is about. Enter NAIC Group number if exists. | ○ NAIC #: NAIC Group #:<br>○ FEIN # |
| 41. | 5C. | If the Payor filing this report is a delegated agent processing claims on behalf of another entity, indicate whether the Payor has previously submitted Clean Claim reports for the delegating entity. | ○ Yes<br>○ No |
| 42. | 5E. | Enter the street address for the Payor submitting this report. | |
| 43. | 5F. | Enter the city of the Payor submitting this report. | |
| 44. | 5G. | Select the state of the Payor submitting this report. | -- Select One -- |
| 45. | 5H. | Enter the Zip Code or Postal Code of the Payor submitting this report (e.g., xxxxx, xxxxx-xxxx). | |
| 46. | 5I. | Enter the contact person name for the Payor submitting this report. | |
| 47. | 5J. | Enter the Payor contact person telephone number (xxx-xxx-xxxx). | |
| 48. | 5K. | Enter the Payor contact person e-mail address (e.g., john.doe@email.com). | |
| | | **Section VI** | |
| 49. | 6A. | Optional - enter any brief explanatory comments (250 characters) concerning the completion and filing of this report. | |

You have successfully completed the form and are now ready to submit it to the Insurance Commissioner. By submitting this report you hereby certify on behalf of the Payor that all information provided is complete, true, and correct to the best of your knowledge and belief in accordance with Maryland laws and regulations.

Submit Clear